OFFICE OF THE INSPECTOR GENERAL
DMHMRSAS

SNAPSHOT INSPECTION
EASTERN STATE HOSPITAL

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OIG REPORT # 80-03

Facility: Eastern State Hospital
Williamsburg, Virginia

Date: March 17-19, 2003

Type of Inspection: Snapshot Inspection / Unannounced

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EXECUTIVE SUMMARY

A Snapshot Inspection was conducted at Eastern State Hospital in Williamsburg, Virginia during March 17-19, 2003. The purpose of a snapshot inspection is to conduct an unannounced inspection pursuant to VA Code: 37.1-256.1.G which specifies that the Inspector General must report on *general conditions, staffing patterns and access to active and contemporary treatment*, at each facility no less than once a year. Additionally, a number of elements from the Quality Improvement Plan agreed upon between The Commonwealth of Virginia and the Department of Justice (DOJ) were reviewed.

Regarding general conditions of the treatment and living spaces at ESH, observations of the facility revealed that the hospital was clean and well maintained. ESH is very institutional in appearance overall which reflects an emphasis on the value of military orderliness that was in vogue at the time of the original construction of these units. At the time of the inspection, most units were uncomfortably warm due to the inflexibility of the institutional heating system to accommodate to spring time variations in temperature.

Regarding active treatment, active treatment programming was observed throughout each section of the facility. At least one of the programs scheduled for the Geriatric units did not occur as scheduled. Concerns about this have been noted on previous OIG visits. (OIG Report 53 conducted in 2002.)

Regarding staffing, ESH in general has had a difficult time in maintaining adequate staffing without use of extensive overtime. There are three nursing staffing elements in the ESH Continuous Quality Improvement Plan that was created in 1996 in response to Department of Justice concerns. Although some sections of ESH meet these requirements, there is not consistent facility wide ability to uniformly sustain these levels of staffing, even with the extensive utilization of overtime. There have been ongoing difficulties with recruitment and retention of RN staff. At the time of the inspection there were approximately 50 RN staff vacancies. Many of the staff are extremely dedicated public servants who work overtime at ESH as opposed to second jobs at other entities wherein they might earn higher wages due to dedication to the patient served by ESH as well as stable state benefits. The ongoing uncertainty about the future of ESH has

contributed to the difficulty in recruiting and retaining new staff. OIG reports have raised concern about this since 2000. (OIG Report 31 conducted in 2000).

Regarding adherence to the ESH Continuous Quality Improvement Plan, there is clear ongoing effort to maintain the core elements of this plan. Many of the elements within this plan have become an established and routine part of treatment and care. These elements include but are not limited to: multidisciplinary treatment and medication treatment planning, physician and professional staffing, provision of contemporary active treatment, pharmacy monitoring and clinical documentation. At this time, the area of greatest concern at this facility is the nursing overtime that is utilized to approximate the safe staffing level set forth in the ESH Continuous Quality Improvement Plan.

PART I: STAFFING ISSUES

1. Number of staff scheduled for this shift for this unit. DSA= Direct Service Assistant	**March 17 – Day Shift** Building 24 – Long Term Adult Unit B – 20 Patients 1 RN, 1 LPN, 3 DSA's Unit C – 23 Patients 1 RN, 1 LPN, 3 DSA's Unit D – 24 Patients 1 RN, 4 DSA's Building 25 – Long Term Adult Unit A – 20 Patients 1 RN, 1 LPN, 4 DSA's Unit B – 20 Patients 2 RN's, 1 LPN, 3 DSA's Unit C – 22 Patients 1 RN, 5 DSA's Building 26 – Long Term Adult Unit B – 24 Patients 1 RN, 1 LPN, 4 DSA's Unit C – 24 Patients 1 RN, 5 DSA's Unit D – 24 Patients 1 RN, 1 LPN, 3 DSA's **March 17 – Evening Shift** Building 2 - Admissions Unit A-1 – 14 Patients .5 RN, .5 LPN, 3 DSA's Unit B-1 – 17 Patients 1 RN, 1 LPN, 3 DSA's Unit C-1 – 11 Patients 1 RN, .5 LPN, 2 DSA's Unit A-2 – 11 Patients 1 RN, .5 LPN, 4 DSA's Unit B-2 – 15 Patients 1 RN, .5 LPN, 4 DSA's Unit C-2 – 15 Patients 1 RN, 3 DSA's

	March 17 – Night Shift Building 34 – Hancock Center Unit A – 16 Patients .5 RN, 1 LPN, 2 DSA's Unit B – 17 Patients . 5 RN, 1 LPN, 2 DSA's Unit C – 18 Patients 1 RN, 3 DSA's **March 18 – Day Shift** Building 34 – Hancock Center Unit A – 16 Patients 2 RN's, 4 DSA's Unit B – 17 Patients 1 RN, 1 LPN, 3 DSA's Unit C – 19 Patients 1 RN, 1 LPN, 4 DSA's Building 4 - Medical Center Unit A – 10 Patients 1 RN, 2 LPN's, 1 DSA Unit B – 8 Patients 1 RN, 1 LPN, 2 DSA's Unit D – 7 Patients 1 RN, 1 LPN, 2 DSA's
2. Number of staff present on the unit?	Observations of unit staffing revealed that staffing was present as indicated above.
3. Number of staff doing overtime during this shift or scheduled to be held over?	Three staff were reported to be working overtime for a shared total of 16 hours.
4. Number of staff not present due absence because of workman's compensation injury?	Interviews with facility staff during the inspection of all shifts on the units listed above indicated that 5 staff members were out on Workman's Compensation leave and one was assigned to light duty.
5. Number of staff members responsible for one-to-one coverage during this shift?	Interviews with facility staff indicated that during the inspection of the three shifts on the units listed above indicated that 6 staff were responsible for a 1:1 coverage.

6. Are there other staff members present on the unit? If so, please list by positions? During the inspection on the day shift Physicians, Social Workers and Activities Therapists were noted in the Hancock Center Buildings; Physicians were noted in the Medical Center and on the Admissions Units.

7. Additional comments regarding staff: Staff were less verbal regarding concerns related to the use of pressure to work overtime than in past inspections. Even though there is still a significant use of overtime at this facility, there has been an emphasis on the liberalizing the use of voluntary overtime so that individuals desiring overtime, and who otherwise might take on a second job elsewhere, are able to work extra hours at ESH. Several staff from different units relayed that this has resulted in an increase in morale.

At the time of the inspection there were approximately 50 RN vacant positions at ESH.

The ongoing use of overtime is a potential serious problem at ESH. Over the last year the OIG has monitored nursing staff overtime on a monthly basis in each of the fifteen facilities operated by Virginia. Each facility is within a different area and faces different local economies. However, of the mental health facilities, ESH by far has the greatest sustained use of professional nursing and direct care overtime as reported through this monthly report. The use of overtime at ESH is greater per patient in comparison with 7 other similar mental health facilities operated by the commonwealth of Virginia. For January and February of 2003, based on reports submitted from each facility to OIG, ESH used an average of 23.5 hours of overtime in RN, LPN and Direct Care staff for each patient. The average use per patient for the same two months in other DMHMRSAS mental health facilities for January and February 2003 ranged from 14.4 to .81 hours of overtime per patient for these first two months in 2003. (Note: the comparison facilities and average hours of nursing and direct care staff overtime per patient for the first two months of 2003 were: **ESH 23.5,** CSH 14.4, SVMHI 9.2, WSH 7.9, Catawba 7.02, NVMHI 6.95, Piedmont Geriatric 6.23, and SWVMHI .81. These numbers were calculated by adding the total hours of reported overtime per month for RN, LPN and Direct Care staff. This number was then divided by the facility census at the beginning of each month. Clinical staff overtime hours per patient were then averaged over these two months to result in the numbers as reported above.)

With regards to nursing and direct care staffing, there are three components that are set forth as goals for nursing staffing. These are clearly established in the ESH Continuous Quality Improvement Plan as negotiated with the Department of Justice in 1996. In general these goals are: 1. The percentage of RN staff for each ward should be 20 to 30%; 2. The number of hours per patient day should be about 5 to 5.5; and 3. There should be one RN per shift for virtually each clinical unit providing care to mentally ill persons.

The February 2003 nursing staffing report maintained by ESH which tracks compliance with the agreed upon staffing goals was reviewed. There are times at ESH when the goal

of having one RN present on each shift on each unit is not met. Primarily this occurs on third or night shift in the geriatric and the admissions units. The units most likely to be low in terms of proportion of RN in the total staffing pattern are the six admissions units. The goal to have 25-30 percent of all nursing staffing be RN level staff, and in February the proportion of RN staff was only 17%.

The current process of a regional Reinvestment Plan serves to compound the already difficult staffing situation at ESH. At the time of this inspection, staff on all levels voiced concern regarding the projected lay-offs of personnel as the facility moves towards the proposed closing of the acute admissions building. Administrative staff indicated that the plans are to place as many staff as possible in existing vacancies in other units within the facility, however as of the time of this inspection, administrative and clinical staff were not aware of details regarding how the currently proposed restructuring of public mental health care in this region would effect staffing needs at ESH. Several staff are or are considering pursuit of employment alternatives due to concerns about perceived instability of ESH. Several staff expressed disinterest in working with long-term or geriatric patients and would leave ESH as opposed to working in geriatric or long-term units. This is in contrast to staff at other Virginia facilities who are very positively inclined toward work with long term and geriatric patients. This may reflect a difference in facility culture.

Tours of units in the Admissions Building (#2) determined that seclusion and/or time out rooms do allow for constant observation. When OIG staff asked unit staff while touring the admissions unit, what their policy and practice for seclusion was, 4 out of 6 units indicated that a staff member sat outside of the room the entire time and viewed the patient through the window every 15 minutes. OIG staff observed this practice while onsite. DI 211 "Use of Seclusion and Restraint" provides direction that persons in seclusion are to be continuously monitored and that this can be accomplished through having a staff person sit outside a seclusion room. While this does provide for a person to be monitored, this does allow for an unstable patient to be out of the direct line of sight of a staff person. Many hospitals reduce the potential risk of harm to resident while in seclusion through the use of video monitoring which enables less intrusive (i.e. there is not the face of a staff looking through a window, but allows for continuous visual monitoring.

Finding 1.1 Clinical staff overtime at ESH is disproportionately high.

Recommendation: Overtime staffing is a critical problem that places the quality of care at risk within this facility. In addition to ongoing internal efforts to maintain staffing, the deployment, availability, and professional development of clinical staff should be a central consideration in the reinvestment effort currently underway.

DMHMRSAS Response: The recruitment for nurses at ESH is a continuous process. Central Office Human Resources has recently created and filled a workforce enhancement position. There are several programs being discussed with local community

colleges to look at ways the facilities can "grow their own" nurses by offering educational incentives to the direct care staff.

The budgetary constraints felt by all State offices this year required several facilities, including ESH, to discontinue retention and hiring bonuses to RNs and other clinical staff. However, ESH is offering more alternative scheduling to the nurses, and this has been received positively. ESH will continue to make every effort to hire sufficient nurses to meet the required HPPD. Providing a safe environment for the patients and staff is the priority for ESH; and this will continue to requires overtime. Voluntary overtime will be utilized over mandatory overtime whenever possible. Although the results of the proposed reinvestment initiative will not be known until after the initiative has been fully implemented, it is hoped that the RNs from the proposed program closures will improve the RN staffing ratio in other programs.

Finding 1.2. Recruitment and retention difficulties for nursing positions continue to result in this facility operating with less than RN per unit per shift.

OIG Recommendation: Continue to work toward the goal of one RN per unit per shift for all shifts and units.

DMHMRSAS Response: See response to Finding 1.2 above.

Finding 1.3: There is destabilizing uncertainty regarding possible lay-offs within the facility as a result of budget reductions as well as the proposed restructuring of the acute admissions unit.

OIG Recommendation: Central Office staff and others involved with planning for the impending restructuring of acute care at ESH provide as much specific information regarding plans with projected timeline implementation to clinical staff and consumers at ESH.

DMHMRSAS Response: Central Office and ESH staff are working with the planning committees to address these important issues pertaining to “reinvestment” of acute admission care to the community. Information on specific plans and timelines will be announced to ESH staff as the planning authorities develop them.

Finding 1.4: During the tour in Building 2, patients in seclusion were not under constant direct visual observation.

OIG Recommendation: Consider the institution of video monitoring equipment which would allow for the capacity to continuously directly observe individuals in seclusion.

DMHMRSAS Response: ESH policy number TX450-35, "Emergency Use of Seclusion or Restraint", states that a patient who is in seclusion must be under constant observation. Further staff in-services on the policy will be given with an emphasis on those staff and supervisors working in Building 2. New computer software for monitoring seclusion and restraint will be initiated in July, and this software will help monitor adherence to the policy. The ESH Administrative and Clinical Leadership will review the feasibility of instituting a video monitoring system for continuous observation of secluded individuals in Building 2. In addition, a system-wide initiative to decrease seclusion and restraint usage will be piloted this fall.

PART II: ACTIVITIES OF THE PATIENTS/RESIDENTS

1. Bed capacity for the unit: **2. Census at the time of the review:**

During the review, the census of all three shifts was found to be:

Capacity:	**Census:**
Building 24 (Long Term)	
Unit B – 22 Beds	20 Patients
Unit C – 23 Beds	23 Patients
Unit D – 24 Beds	24 Patients
Building 25 (Long Term)	
Unit A – 19 beds (1 Cot)	20 Patients
Unit B – 19 Beds (1 Cot)	20 Patients
Unit C – 19 Beds (3 Cots)	22 Patients
Building 26 (Long Term)	
Unit B – 24 Beds	24 Patients
Unit C – 24 Beds	24 Patients
Unit D – 24 Beds	24 Patients
Building 2 (Admissions)	
Unit A-1 – 14 Beds	14 Patients
Unit B-1 – 18 Beds	17 Patients
Unit C-1 – 16 Beds	11 Patients
Unit B-2 – 18 Beds	15 Patients
Unit C-2 – 18 Beds	15 Patients

Capacity:	**Census:**
Building 34 (Geriatric)	
Unit A – 20 Beds	16 Patients
Unit B – 20 Beds	17 Patients
Unit C – 20 Beds	19 Patients

Building 4 (Medically Complex)

Unit A – 25 Beds	10 Patients
Unit B – 25 Beds	8 Patients
Unit D – 25 Beds	7 Patients

3. Number of patients/residents on special hospitalization status
Interviews with staff indicated that during the inspection period, four patients were on special hospitalization status either in the Medical Center on grounds or at Williamsburg Community Hospital.

4. Number of patients/residents on special precautions?
Interviews with staff on units inspected indicated that 101 patients were noted to have a special precaution addressing issues for falls (40), choking (55), seizure (1), diabetes (3), or contact (2).

5. Number of patients/residents on 1 to 1?
Interviews with staff on units inspected indicated that 6 patients within the facility during the time of the inspection were on 1:1 coverage either during activities, for safety precautions or due to self injurious behavior.

6. Identify the activities of the patients/residents?
During the day and evening shift the OIG staff toured residential and treatment areas and observed activities that were conducted. Activities of patients differed depending on skill level. Long Term Adult Patients leave their buildings to attend day treatment in either the Davis Building or Building 12**.** The selections of activities that are offered are listed in the next section.

Geri-Active Program – GAP: The activities offered for the Geriatric population are provided in the Hancock Center, which is a group of 4 buildings, (3 of which are residential). The Program for the Geriatric population is the Geri –Active Program (GAP). The GAP is primarily targeted for higher functioning individuals and is offered from 9:30– 11:30am on weekdays. The morning is split into two sections in which patients that are in the program leave their wards for activities in other buildings or other units.

The broad goal for this program is to enhance skill sets for the patients as well as to prevent the loss of an individual's current level of functioning. The two sessions of the GAP program were completed as scheduled. Those that did not participate in the Gap program had other programs scheduled throughout the day, with two to three 30 to 45 min activities scheduled.

Other programming options for the geriatric population in Building 34:
Observations of Building 34 activities demonstrated that many staff did not understand the daily schedule of the overall program. When asked, staff had a hard time answering questions abut the daily schedule and the content of activities. In addition all wards in Building 34 did not offer programming throughout the day.

On one of the days of the inspection, A Ward had two activities scheduled, Worship, scheduled in the morning for 30 minutes; and Recreation Therapy, scheduled in the afternoon for 45 min. The Worship activity did not occur, because the facilitator did not show up, but the afternoon Recreational Therapy did occur for 45minutes.

B ward had three activities scheduled, Worship, Dance Therapy and a Van Ride (for those that had off ground privileges). All three activities occurred as scheduled.

C ward had a movie in the morning, which was part a staff conducted activity designed for social interaction activity, In addition, Dance Therapy occurred as was scheduled in the afternoon.

During the times there were no activities offered, patients sat and watched TV, slept or were in bed. Occasionally there was someone walking through the unit or listening to the radio, but for the most part, without a scheduled activity, patients sat. During scheduled activities, patients participated with the group or independently. The best example was on C ward when the Dance Therapist turned off the TV and turned on some music (Motown), many patients started to move on their own. Though the Dance Therapist was there to work with just three of the patients, some of the others were inspired to dance on their own.

Observations of the activities conducted during the day in building 34 clearly indicated that patients responded during the activities conducted as opposed to the times when there no activities and most just sat with the TV on and watched or slept.

Building 12 Psychosocial Rehabilitation Programming:
A member of the inspection team observed several groups offered in Building 12. The psychosocial rehabilitation programming that occurs in this setting is designed to meet the active treatment needs for the chronic care population who are more likely to benefit from increased supervision. Group content and session lengths are appropriately modified in order to take into consideration the stability, level of functioning and cognitive ability of the patients. The discharge planning group uses modules to highlight issues important to successful re-entry into the community such as medication and symptom management.

The facilitator engaged the patients in a discussion, which was paired with written materials for further review

A tour was conducted of the Community Awareness Program (CAP). This day treatment program provides structured activities for individuals with more persistent negative symptoms that can diminish a person's ability to successfully interact in life and with other people. The program engages each person in a variety of activities that supports socialization and other skills that can sustain the person's efforts towards community re-integration.

7. What scheduled activities are available for patients/residents during this shift?
Inspection tours indicated that most scheduled activities occur between 9:30 am and 3:00 pm. The activities are scheduled and patients are assigned based on treatment needs. The two main sets of activities scheduled are in the Hancock Center for the Geriatric population and the Brown Building for the Long Term Adult population. The GAP activities scheduled in the Hancock Center that were observed by OIG staff included the following: Community Integration; Grounds Crew; Music Group; Yoga Health and Mobility; Chair Exercises; Social Time; Relaxation Group; Holiday Celebrations; Bell Choir; Health & Nature; Fitness; Worship; Leisure Fun; Let's Talk; Games; Dance Therapy; Story Time; Directive Group; Poetry and Prose; Pet Visits; Van Ride; Bingo; Canteen; Easy Listening.

The activities scheduled for the Long Term Adult population included: Music; Sensory Stimulation; Music Movement; Music Therapy; Library; Emotional Awareness; Exercise/Walk; Grounds Crew; Horticulture; Juggling Life for Satisfaction; Life Skills; Symptom Management; Woodshop; Art Therapy; Arts& Crafts; Community Awareness; Health Issues; Boosting your Self Esteem; Recovery Pathwork; Swim Lesson Group; NGRI Group; Housekeeping; Basic Education; Cognitive Awareness Program; Community Re-Entry; Problem Solving; .Mental Health Issues; Positive Image; Substance Abuse Education and Life Skills.

8. Are smoke breaks posted?
Tours of units indicated that the majority of units had smoke breaks posted.

9. Do patients/residents have opportunities for off-ground activities?
Facility staff indicated to inspection staff that off ground activities are determined based on the privilege that a patient has been assigned. For those with the appropriate privileges, van rides, special events trips, trips to promote community interaction including to a restaurant or store occur weekly.

10. As appropriate, do patients/residents have opportunities for snacks?
Interviews with staff indicated that snacks do occur in the morning and evening and through out the day as appropriate. Special dietary needs and preferences are able to be accommodated.

11. Other comments regarding patient activities: None

OIG Finding 2.1: Eastern State Hospital provides a variety of psychosocial rehabilitation programs.

OIG Recommendation: None.

DMHMRSAS Response: Concur

OIG Finding 2.2: Staff interviewed in Building 34 were not able to accurately identify whether active treatment programs were available for patient participation. At least one activity program that was scheduled did not occur.

OIG Recommendation: continue with the goal or providing quality active treatment programs that promote healthy recovery for individual patients.

DMHMRSAS Response: Concur. The ESH Clinical Leadership Team in geriatrics and specifically the RNC assigned to Building 34 and the OT Supervisor will redistribute the revised definition of Active Treatment to all geriatric staff, particularly those staff assigned to Building 34. This will include re-educating the staff to increase their understanding of the active treatment process, their role in those treatment/care activities, and their ability to articulate the daily schedule for patients' health and well-being.

PART III: ENVIRONMENTAL ISSUES

AREA OF REVIEW: Common Areas	Comments and Observations
1. The common areas are clean and well maintained.	Tours of all common and residential areas of units inspected confirmed that each area was clean, essentially free of odors and well maintained.
2. Furniture is adequate to meet the needs and number of patients/residents.	Tours of each unit indicated that furniture, in common areas, was adequate to meet the needs and numbers of patients on each unit.
3. Furniture is maintained and free from tears.	Tours of each residential area indicated that furniture was free from tears and is well maintained.
4. Curtains are provided when privacy is an issue.	Tours of residential units demonstrated that window coverings are provided for privacy from the outside. In addition, for those geriatric patients in the open wards, curtains are provided around beds for privacy.

5. Clocks are available and time is accurate.	Tours of all 19 units indicated that clocks were available in public areas and had the correct time.
6. Notification on contacting the human rights advocate are posted.	Tours of each unit indicated that a poster providing information on how to contact the Human Rights Advocate is posted in a public area of each unit.
7. There is evidence that the facility is working towards creating a more home-like setting.	Tours of 19 of the residential units at the facility indicated that the facility was working towards a more homelike atmosphere as appropriate for the population. Each residential unit had different homelike aspects. There areas decorated with stenciling, faux plants, upholstered furniture, pictures, quilts and stuffed animals. Some units had large arched windows decorated with valences and pictures on the wall. All areas had a TV and books and music available for clients.
8. Temperatures are seasonally appropriate.	Tours of units during all three shifts confirmed that temperatures were warm outside and especially warm inside. When asked staff commented that buildings and grounds respond in a timely fashion to make adjustments to the thermostats. Most staff indicated that the old heating and cooling systems often result in uncomfortable temperatures during seasonal transitions.
9. Areas are designated for visits with family, etc., which affords privacy. Visiting hours are clearly posted.	Tours of visiting areas and observations of family's visiting with patients indicated that the areas designed as visiting areas were set up well.
10. Patients/residents have access to telephones, writing materials and literature.	Interviews with staff indicated that clients have access to communication materials and literature. There is a phone in each dayroom that can be used for local calls. Long distance calls are arranged through the Social Worker. Writing materials are available and provided by staff upon request and the facility will stamp and mail all items.
11. Hallways and doors are not blocked or cluttered.	Tours of units indicated that hallways and doors are not blocked and cluttered.
12. Egress routes are clearly marked.	Tours of each unit indicate that egress routes are clearly marked.

13. Patients/residents are aware of what procedures to follow in the event of a fire.	Interviews with staff and patients indicated that fire drills are conducted once per shift per month and patients were aware of where to go for safe egress. For those buildings that have medically fragile residents, Staff indicated that fire alarms are tested weekly and staff are quizzed on appropriate evacuation procedures, instead of evacuating patients from the building every month.
14. Fire drills are conducted routinely and across shifts.	Interviews with staff and patients indicated that fire drills are conducted once per shift per month and patients were aware of where to go. For those buildings that have medically fragile residents, Staff indicated that fire alarms are tested weekly and staff are quizzed on appropriate evacuation procedures, instead of evacuating patients from the building every month.
Bedrooms	**Comments and Observations**
1. Bedrooms are clean, comfortable and well-maintained.	Tours of 19 residential units indicated that all bedrooms overall were clean and well maintained.
2. Bedrooms are furnished with a mattress, sheets, blankets and pillow.	Tours of bedrooms on the 19 units indicated that each client is furnished with a mattress, sheets, blankets and a pillow. If there is a need for additional items there are linen closets on each unit or in each building.
3. Curtains or other coverings are provided for privacy.	Tours of the residential units confirmed that curtains and other coverings are provided for clients privacy. In the adult long term care units the blinds are located inside the window panes, in the units for geriatric patients, curtains are provided on windows and around beds for privacy.
4. Bedrooms are free of hazards such as dangling blind chords, etc.	The residential areas toured were free from hazards.

5. Patients/residents are able to obtain extra covers.	Interviews with staff indicated that clients are able to obtain extra linens and covers.
6. Patients/residents are afforded opportunities to personalize their rooms.	Interviews with staff and tours of bedrooms indicated that clients are given the opportunity to personalize their rooms.
Seclusion Rooms	**Comments and Observations**
1. Seclusion and/or time out rooms are clean.	Tours and observations indicated that seclusion and/or time out rooms were clean, except for some located in the Admissions building, which had brown dripping stains on the ceilings.
2. Seclusion and/or time out rooms allow for constant observations.	Tours of units indicated that seclusion and/or time out rooms do allow for constant observation. When OIG staff asked unit staff while touring the admissions unit, what their policy and practice for seclusion was, 4 out of 6 units indicated that a staff member sat outside of the room the entire time and viewed the patient through the window every 15 minutes.
3. Bathrooms are located close to the seclusion or time-out areas.	Tours of units indicated that seclusion and/or time out rooms are located next to the time out bathrooms.
Bathrooms	**Comments and Observations**
1. Bathrooms were clean and well maintained	Tours of unit bathrooms indicated that all were cleaned and well maintained.
2. Bathrooms were noted to be odor free.	Tours of unit bathrooms across all shifts indicated that all were odor free.
3. Bathrooms were free of hazardous conditions.	Tours of unit bathrooms indicated that all were free of hazardous conditions.
Buildings and Grounds	**Comments and Observations**
1. Pathways are well-lit and free of hazardous conditions.	Tours of outside grounds indicated that pathways were well lit and free of hazardous conditions.

2. Buildings are identified and visitor procedures for entry posted.	Upon entering the hospital all visitors are required to check in, receive a visitors badge and be escorted to their location.
3. Grounds are maintained.	A driving tour of the grounds confirmed that they were well maintained.
4. There are designated smoking areas with times posted.	A tour noted that there are designated areas for smoking.
5. Patients/residents have opportunities to be outside.	Interviews with staff indicated that clients with the appropriate privileges regularly go outside on and off grounds, weather permitting.

Other comments regarding the environment: One of the program rooms in Building 12 had brightly colored balls hanging from "fishing wire". The balls appeared to be glass. Both the balls and the wire can present a risk to patients. Staff indicated that the decorations are positioned so as to minimize risk. It was also maintained that patients are never in the rooms unaccompanied by staff.

Eastern State also has constructed a therapeutic labyrinth on the grounds in order to provide both the staff and the patients with this additional restorative environment.

OIG Finding 3.1: Tours of 19 units revealed the facility overall was generally clean and well maintained.

OIG Recommendation: None.

DHMRSAS Response: Concur. ESH Housekeeping Services takes pride in maintaining the cleanliness of all facilities.

OIG Finding 3.2: The temperature in a majority of the units toured was uncomfortably warm throughout this inspection.

OIG Recommendation: None.

DMHMRSAS Response: Due to the nature of commercial heating and cooling systems, temperatures will vary greatly during the transitional seasons of Spring and Fall. Air conditioning is usually turned on for the season on May 1st of each year.

OIG Finding 3.3: An activity room in Building 12 had glass ornaments and nylon wire as a part of the decorations which were very attractive but could pose safety risks.

OIG Recommendation: Facility risk management may want to review the risks Vs benefits in using these particular objects as decorations.

DMHMRSAS Response: The Department appreciates the recognition of the attempts by ESH to improve the appearance of the facility. The ornaments referred to in the OIG report were plastic, not glass and as such did not pose as great a safety risk as was thought. The lengths of nylon wire on the paper decorations hanging from the ceiling were checked and were found to be less than 10 inches in length. These were hanging from the ceiling at a height where an average height person would require a chair or ladder to remove them. The facility further shortened the lengths of nylon used to hang the ornaments.

In addition, patients are never allowed in the art room without staff. Seasonal decorations will continue to be evaluated to avoid any possible hazard to patients or staff.

PART IV: COMPLIANCE WITH SELECTED PORTIONS OF THE ESH CONTINUOUS QUALITY IMPROVEMENT PLAN

Eastern State Hospital was one of five facilities within Virginia that was sued by the federal government through the Department of Justice for violations under the Civil Rights of Institutionalized Persons Act (CRIPA). CRIPA provides that persons in state operated institutions have a right to receive active treatment in a safe environment. A plan for continuous quality improvement was agreed upon between these parties. This agreement outlined a number of details. The execution of this plan resulted in a major reorganization of virtually all clinical services within ESH. In 1999 the final tour of ESH by the Department of Justice was completed. At this time DOJ determined that ESH had implemented the ESH Continuous Quality Improvement Plan as agreed upon between the Commonwealth of Virginia and the Department of Justice.

With this particular OIG inspection, in addition to the basic components of the required annual inspection of conditions, staffing and access to active treatment, several basic components of the ESH Continuous Quality Improvement Plan (ESH CQIP) were reviewed to determine the current status of the ongoing implementation of this plan. The ESH CQIP was originally created seven years ago, in 1996.

A. General Medical Care:

1. **Physician Staffing**

Eastern State Hospital maintains a compliment of 19 psychiatrists and seven medical care physicians. The number of physicians currently employed by ESH is consistent with those established in the ESH CQIP.

Physician assignments are as follows:

Building 2 (Acute admissions services)
Seven psychiatrists are assigned for coverage in Building 2 and one primary care physician.

Building 24 (Forensic services)
Three psychiatrists

Building(s) 25 and 26 (Continuing Rehabilitation Services)
Five psychiatrists and one medical physician

Building(s) 32, 34 and 36 (Geriatric Psychiatric Services)
Four psychiatrists and three medical doctors

Building 4 (Medical Services)
Patients receiving services in Building 4 have a medical problem as the primary focus of care. There are not any psychiatrists assigned to this service. The mental health issues of patients within this building are treated by ESH psychiatrists on a consultant basis. Two primary care physicians and a certified nurse practitioner provide medical coverage.

OIG Finding 4.1: Eastern State Hospital maintains appropriate psychiatrist and primary care physician staffing.

OIG Recommendation: None. Continue this level of medical staffing.

DMHMRSAS Response: Concur. Appropriate staffing of psychiatrist and primary care physician positions will continue to be a high priority at ESH.

2. 24-Hour Medical Coverage

Background: Interviews with administrative staff and a review of policy demonstrated that there was medical and psychiatric coverage provided 24 hours a day. After normal working hours and during the weekends, if the primary physician on grounds is a medical physician, a back up psychiatrist is on call and must be available to come into the facility immediately in the event of urgent mental health related problem. If a psychiatrist is on call, a there is a primary care physician for medical backup.

OIG Finding 4.2: ESH maintains a mechanism for providing round-the-clock on-site medical coverage.

OIG Recommendation: None. Continue this level of access to care.

DMHMRSAS Response: Medical coverage will continue to be available on a 24-hour per day basis at ESH.

3. Falls Prevention Program

Background: The facility has established protocols for a falls prevention program. The primary goals for this program are to decrease the number of falls within the facility and to minimize the severity of injury if a fall occurs. During the initial and annual nursing care assessments, each patient is assessed for the risk of falls. An interdisciplinary approach to falls risk assessments are used for patients assigned to the Hancock Geriatric Center. Falls risks are assessed through information in the Minimum Data Set (MDS) The MDS assessment is completed every three months.

Patients determined to be at high risk for falls have a falls prevention care plan developed. This includes a number of interventions in the general environmental conditions, such as keeping the patient's room clutter free or through the introduction of specialized equipment such as a walker. The facility has also established a mechanism for reviewing the circumstances associated with falls for the purpose of developing performance improvement initiatives. 15 of the 19 records reviewed by members of the OIG had evidence of completed falls assessments as outlined by policy.

OIG Finding 4.3: A falls prevention program has been implemented and currently is a mature and established part of the assessment process.

OIG Recommendation: None. Maintain this level of monitoring for falls.

DMHMRSAS Response: ESH will continue to monitor, track, and trend data pertaining to the existing falls prevention program.

4. Dysphasia Program

Background: The development of a Dysphasia program was agreed to within the ESH Continuous Quality Improvement Plan. This program is managed by a Speech Therapist and is designed to reduce the risk of fatal aspiration and other potential serious problems that can be associated with impaired and painful swallowing. Death from aspiration and associated recurrent pneumonia can be complications of untreated swallowing difficulties, particularly in the geriatric population. Chart review indicated that this program is apparent in the management of a number of individuals in the medical units in building 4 where the majority of patents are at some choking risk. Additionally there were no temporary Naso-gastric tubes in place. For a variety of medical reasons, it is safer long term to use surgically placed gastric tubes. Several patients are fed through gastric tubes in building 4.

OIG Finding 4.4: There was evidence of an established dysphasia program at ESH.

OIG Recommendation: None. Continue the administration of this essential program.

DMHMRSAS Response: ESH will continue with their well-established dysphasia program under the current program guidelines.

5. Use of Barium Swallows

Background: One component of the CQIP specified that modified Barium Swallows would be performed on individuals identified with dysphasia. The Barium Swallow or Upper GI series is an X-ray completed of the upper digestive tract in which barium is used to enhance the X-ray. In review of 19 records, there was no evidence that Barium swallows were being conducted. This may have been a function of the particular charts that were reviewed.

OIG Finding 4.5: There was not any evidence of modified barium swallows being completed in the charts reviewed.

OIG Recommendation: It is requested that ESH provide information regarding the current policy or practice regarding the use of modified barium swallow in the evaluation of dysphasia.

DMHMRSAS Response: Eastern State Hospital's current document identifying the criteria for use of Modified Barium Swallows (MBS) needs updating and revision, as it does not reflect current practice. All patients who have difficulty swallowing are referred to the speech/language pathologist who may or may not recommend an MBS. The decision to order the MBS is made by the medical staff or treating physician. The protocol will be reviewed and updated by the identified clinical disciplines for approval by the Clinical Cabinet.

B. Medication Practices:

1. Medication Treatment Plan

Background: Eastern State agreed to create and maintain a medication treatment plan in the record of each patient treated with psychiatric medication. Interviews with administrative staff revealed that the facility developed a medication form that captures a number of elements important to effective medication management. The plan prominently notes potential side effects. The completion of patient education and documentation of informed consent is a part of this form.

Additional to this, there was concern that at one time patients at ESH did not have adequate access to contemporary psychiatric medications which are generally much better tolerated than older medications, but tend to be very expensive. The Pharmacy and

therapeutic committee closely follows trends in use of contemporary medications. In 1999, 60.8% of patients requiring an antipsychotic medication were on the new medication. By 2002 this had increased to 73.5%. (During this same time frame, the cost of the use of these new medications doubled, from an annual cost of .64 million per year for new medications, to a cost of 1.3 million dollars.) Chart reviews indicate widespread use of these new medications although there is some preservation of use of the older medications for the acute management of unstable individuals. It is to the credit of facility administration that there is no policy regarding restriction of access to these new medications. Information is provided to medical staff regarding the cost of these medications.

In a number of charts reviewed there was not clear documentation in the progress notes regarding the purpose of medication change and goal associated with changes. Overall, medication use was appropriately conservative; there is very limited use of PRN medication. The use of two or more antipsychotics for the same patient is uncommon and is tracked through the central pharmacy.

OIG Finding 4.6: In each chart reviewed, there was a medication treatment plan that had been developed for the corresponding patient.

OIG Recommendation: None. Maintain this program, this has been a helpful tool in facilitating a more objective evaluation of the efficacy and risk Vs benefit of each mediation utilized for each patient.

DMHMRSAS Response: ESH will continue to develop medication treatment plans for each patient.

OIG finding: 4.7 Within several charts it was difficult to establish the rationale for change in medication.

Recommendation: Consider a more formal review of this through the Clinical Pertinence Review mechanism.

DMHMRSAS Response: The ESH Medical Records Committee, which handles Clinical Pertinence, will review their current practice and will make recommendations to improve documentation of the rationale for medication change rationale in patient charts.

2. Reporting Adverse Drug Reactions (ADR)

Background: Adverse Drug Reactions (ADR) reporting involves the reporting and tracking of adverse reactions patient have in response to treatment. ESH has created and follows on a monthly basis all reported ADRs. Additionally there is a very thorough annual ADR that is created and reported on to medical staff. The majority of averse reactions are reported by physician staff into this system.

OIG Finding 4.8: Reporting of Adverse drug reaction was systematized and has remained as an integral component of facility administration.

OIG Recommendation: None. Continue this established program that results in increased awareness of the frequency of side effects for all medical staff.

DMHMRSAS Response: Concur. The ESH Pharmacy staff will continue to provide excellent resources to staff on the issue of adverse drug reaction prevention.

C. Psychiatric care:

1. Physician In-services

Background: Interviews with administrative staff and a review of the general medical staff and P& T committee minutes revealed several mechanisms established by the facility for providing continuing education information regarding pharmacology for physicians. The pharmacist has developed a newsletter, which is distributed on a monthly basis to all physicians. In addition, copies are maintained in the back of the formulary book for easy reference.

Training opportunities are provided through the Distant Learning Network and PsychLINK programs. Examples of CME program topics available are: New Vistas in the Treatment of Bipolar Disorder and Antipsychotic Therapy: Understanding Mechanisms of Action to Optimize Patient Response .

OIG Finding 4.9: ESH has several mechanisms established for providing continuing education and training for the physicians including the pharmacy newsletter which serves as a good source of information.

OIG Recommendation: None. There are several opportunities for physicians to maintain a current good working knowledge of standards in contemporary medication and treatment modalities.

DMHMRSAS Response: Concur. ESH will continue to provide vital, up-to-date training on a wide variety of subjects to its physician and professional staff.

2. Clinical Pertinence Review

Background: The current clinical pertinence review process was reviewed. This process was designed in order to monitor the accuracy of diagnosis. Elements are developed and tracked for frequency of successful implementation. Interviews with administrative staff and a review of the medical records committee minutes revealed that there is a well-established on-going quarterly clinical pertinence review process. Among the elements identified in the quarterly reports for psychiatric physicians reviewed were: the completion of history and physicals within 24 hours of admission, the filing of a dictated comprehensive admission summary in the record within 60 hours and the development of

a medication treatment plan with a review of side effects for each patient. Elements are changed as the outcome of the monitoring process demonstrates that the goals are consistently100% accomplished. Each major professional discipline at ESH has performance elements that are monitored in this system. The Clinical pertinence review process for psychology staff was also reviewed.

OIG Finding 4.10: ESH has maintained a clinical pertinence review process regarding key performance indicators as established through policy and procedures.

OIG Recommendation: None. This is a well-established process at ESH.

DMHMRSAS Response: Concur.

3. The completion of CT scans for persons diagnosed with dementia.

Background: Interviews with administrative and medical staff revealed that it is a recognized practice at the facility to order CT scans for persons diagnosed with dementia. Of the five records reviewed of individuals diagnosed with dementia there was evidence of the test completed in all five.

OIG Finding 4.11: It is a recognized practice of the facility to obtain CT scans for persons diagnosed with dementia.

OIG Recommendation: None

DMHMRSAS Response: Concur. ESH will continue the practice of obtaining CT scan for dementia patients.

4. General Observations:

There were a number of elements within the ESH Continuous Quality Improvement plan that were not reviewed in detail with this inspection. In general it is evident that the structure of the multidisciplinary treatment planning process is intact and operational in each of the treatment areas at ESH. The clinical pertinence review process that focuses highly on monitoring this process supports this.

The treatment mall, which was developed to address the concerns that patients at ESH were not receiving active treatment, is well established and continues to provide a variety of programming designed to promote recovery and successful adaptation to facility and community life. Additional to the central treatment mall for longer-term mentally ill persons, there are numerous treatment opportunities for patients within the admission unit as well as on the Geriatric unit.

Review of the discharge plans in several charts found that the involvement of corresponding Community Service Board discharge planning staff in the discharge process was variable. For some individuals there was good documented involvement of

the CSB, for others there was virtually no involvement. Given the current initiative to reorganize services in this region by way of a transfer of facility resources in order to enhance community services, communication and coordination around discharge as well as admissions will need to be reviewed.

OIG would like to extend appreciation to ESH staff who were extremely cooperative with OIG staff throughout this inspection.